STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225232	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Holyoke	282 Cabot Street Holyoke, MA 01040

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 45435 Based on record review and interviews the facility failed to implement their grievance policy and assist one Resident (#56) to file a grievance out of a total sample of 21 residents. Specifically, the facility staff failed to follow up and investigate a report of a missing electric razor. Findings include: Review of the facility policy titled Grievances, dated 8/2019 indicated the following: -Staff members are encouraged to assist residents in filing a grievance and/or complaint when the resident believes that his/her rights have been violated. -Upon receipt of a grievance, complaint report or the missing items form, the Director of Social services will begin an investigation into the allegation. Resident #56 was admitted to the facility in August 2023 with diagnoses that include Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors). Review of the Minimum Date Set (MDS) Assessment, dated 3/29/24, indicated the Resident had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) exam score of 10 out of a possible 15 and, and was dependent on staff for personal hygiene. Review of the Nurses Notes dated 12/10/23, indicated the Resident's family reported a missing electric razor. The charger was plugged into the wall in his room, but the razor could not be found. During an interview on 5/23/24 at 5:08 P.M., Social Worker (SW) #1 said she had not been aware of the missing razor until the surveyor had informed her of the Nurses Note dated 12/10/23. SW #1 said that since that time, she had talked with staff on the unit, and they remembered the razor going missing. SW #1 said she had reviewed the grievance log and said there was no evidence that a grievance form had been filled out or that an investigation into the missing razor had been initiated. SW #1 said the process for missing items is that facility staff should assist the resident or family to fill out a grievance form and the staff should give the form to a Unit Manager or anyone in management. She said an investigation should have been initiated and if the missing razor was not found the Resident should have been reimbursed.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 50563 Based on interviews, records review and policy review, the facility failed to implement their abuse policies and procedures. Specifically; 1) The facility failed to investigate an allegation of abuse according to policy and procedure for one Resident (#30), out of a total of 21 sampled residents resulting in potential for psychological harm. 2) The facility failed to implement their employee screening procedures to ensure new employees have no previous abuse, neglect or mistreatment findings for one staff member (CNA #4) out of 5 staff members reviewed. Findings include: Review of facility policy titled Abuse: Investigation, dated March 2022, indicated but was not limited to the following: -The nursing supervisor will coordinate the interview process during the shift in which the event was reported. Any individual who may have knowledge of the event should be interviewed. This includes the alleged victim, employees working during the shift when the event was discovered/reported, as well as visitors and other residents who may have witnessed something. -Documentation of the incident/alleged incident will be entered into the resident's medical record Review of the facility policy titled Abuse Screening, dated March 2022, indicated but was not limited to the following: -The Nurse Aide Registry is checked prior to employment for all facility employees. If applicant indicates employment in another state, that Nurse Aide Registry is checked. -The person responsible for hiring will ensure that the request for the required criminal background check (CORI) has been submitted no later than the date of initial orientation. -Documentation on all of the above information will be maintained as part of the employment record. 1) Resident # 30 was admitted to the facility in June 2023 with diagnoses of Anxiety Disorder (feelings of fear, dread, uneasiness) and Depression (a recurring feeling of sadness/hopelessness, loss of interest in activities). Review of Resident #30's Minimum Data Set (MDS) Assessment, dated 4/3/24, indicated a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact) out of 15. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/24 at 1:00 P.M., Resident #30 made an allegation of verbal abuse by staff to the surveyor. The Resident alleged the following: -Approximately 4 months ago the Resident asked a Certified Nurse Aide (CNA)for a ginger ale, and she told him/her no, she didn't feel like it. -The Resident reported the interaction relative to ginger ale to the Man Director. -The CNA returned the next day and made comments to the Resident that he/she likes to report people. The Resident felt afraid the CNA would hit her. -The Resident observed the CNA to eat off residents' tray and then pass the tray to those residents 4 separate times during a meal. -The Resident reported the tray incident to a staff member. -The CNA came into the Resident's room and said to the Resident if he/she kept reporting people he/she'd find him/herself on the floor with his/her head split open. -The Resident reported the CNA's threatening comments to the head nurse. -The CNA was moved to a different unit (fourth floor). The Resident still saw her when he/she would go upstairs to play bingo and the CNA would give him/her the middle finger. -The Resident reported the CNA's gestures to an activities assistant. -At the conclusion of the interview, the Resident said that he/she did not feel safe. Immediately after the Resident interview, the surveyor informed the Director of Nursing (DON) and Administrator of the allegation. The DON said an investigation of the allegation and a report to Department of Public Health (DPH) would be initiated immediately. A review of Resident #30's May 2024 interdisciplinary progress notes on 5/24/24 at 8:30 A.M. indicated no documentation of interview or follow-up on reported allegations. During an interview on 5/24/24 at 8:38 A.M., Social Worker (SW) #2 said that she had not been working on this investigation, but that SW #1 had been unable to interview the Resident because he/she had attended activities during the day on 5/22/24 and 5/23/24. SW #2 said the expectation for an allegation of abuse would be that the resident would be interviewed the same day as the allegation was received, and that the interview or attempted interview(s), (if unable to obtain the interview), would be documented in a social work progress note within the resident's clinical record. SW #2 further said that there would be an expectation of psychosocial follow-up for this type of allegation with a minimum of three visits over about a 3-week period with the first visit typically occurring the day after the allegation was made. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a typed, unsigned addendum to SW #2's summary of interview with Resident #30 dated 5/24/24 at 10:25 A.M. indicated the surveyor's reported allegation to SW #1 and that the Resident was unable to meet with the Social Worker when three attempts were made on 5/22/24 and three attempts were made on 5/23/24 due to his/her attendance in activities. During a review of Resident #30's Interdisciplinary Progress Notes on 5/24/24 at 11:00 A.M., a late entry Nursing Progress Note written by the DON for 5/22/24 at 1:30 P.M. was entered into the medical record on 5/24/24 at 10:30 A.M. that indicated the Resident was provided support by social services. During an interview on 5/24/24 at 11:00 A.M., Resident #30 said the first-time staff met with him/her to discuss the allegations reported to surveyor on 5/22/24, was that morning (two days later). When asked, Resident #30 said that no one had attempted to meet with him/her when he/she was at an activity. During an interview on 5/24/24 at 11:48 A.M., Activity Assistant (AA) #1 said she has worked at the facility for many years as an activities assistant and is familiar with Resident #30. AA #1 said that a couple months ago when the Resident resided on the second floor, he/she brought a concern about CNA #5 to her. AA #1 said the Resident would not specify the concern and only reported to her that he/she did not like CNA #5 at that time. AA #1 said she brought the Resident down to speak with the former administrator and former director of nursing who worked at the facility at the time the concern was brought to her, and CNA #5 was moved to the fourth floor. During an interview on 5/24/24 at 1:46 P.M., the Administrator said that the involved resident should be interviewed right away when allegations of abuse are made. The Administrator said any staff member can complete the interview and that evidence that the interview occurred or had been attempted should be documented in the resident's interdisciplinary progress notes. During an interview on 5/24/24 at 4:03 P.M. the DON said the expectation for investigating abuse means the involved resident would immediately be interviewed about the allegation. The DON said this process did not occur for Resident #30's allegation of abuse. Relative to the late entry Nursing Progress Note dated 5/22/24 at 1:30 P.M., the DON said she entered this progress note because she thought that someone would interview the Resident about the allegation of abuse but said that she did not verify the interview occurred before documenting the nursing progress note. 2) CNA #4 was hired to the facility in March 2023. Review of CNA #4's Human Resources (HR) file indicated no evidence of a CORI check or Nurse Aide Registry check being completed. During an interview on 5/24/24 at 3:20 P.M., Regional Consultant Nurse #1 said that the facility was unable to provide documentation of a CORI check or Nurse Aide Registry check for CNA #4.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 50563 Based on observation, interviews, records review and policy review, the facility failed to prevent the potential for further abuse for one Resident (#30) out of a total of 21 sampled residents. Specifically, the facility failed to follow their policy and take steps to protect the Resident and prevent him/her from the potential of further abuse during an investigation of an allegation of abuse. Findings include: Review of the facility policy titled Abuse: Identification & Reporting dated March 2022 indicated but was not limited to the following: -All alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in process Review of the facility policy titled Abuse: Investigation dated March 2022 indicated but was not limited to the following: -The nursing supervisor will take appropriate steps to protect the resident, if applicable, from further mistreatment and to ensure appropriate care is provided. Separate accused/suspected employee or resident from alleged victim and other residents. Suspension of employee pending investigation as indicated. -Interviews of appropriate individuals. The nursing supervisor will coordinate the interview process during the shift in which the event was reported. Any individuals who may have knowledge of the event should be interviewed. This includes the alleged victim, employees working during the shift when the event was discovered/reported, as well as visitors and other residents who may have witnessed something. Resident # 30 was admitted to the facility in June 2023 with diagnoses of Anxiety Disorder (feelings of fear, dread, uneasiness) and Depression (a recurring feeling of sadness/hopelessness, loss of interest in activities). Review of Resident #30's Minimum Data Set (MDS) Assessment, dated 4/3/24, indicated a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact) out of 15. During an interview on 5/22/24 at 1:00 P.M., Resident #30 made an allegation of verbal abuse by staff to the surveyor. The Resident alleged the following: -Approximately 4 months ago the Resident asked a Certified Nurse Aide (CNA)for a ginger ale, and she told him/her no, she didn't feel like it. -The Resident reported the interaction relative to ginger ale to the Man Director. -The CNA returned the next day and made comments to the Resident that he/she likes to report people. The Resident felt afraid the CNA would hit her. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Resident observed the CNA to eat off residents' tray and then pass the tray to those residents 4 separate times during a meal. -The Resident reported the tray incident to a staff member. -The CNA came into the Resident's room and said to the Resident if he/she kept reporting people he/she'd find him/herself on the floor with his/her head split open. -The Resident reported the CNA's threatening comments to the head nurse. -The CNA was moved to a different unit (fourth floor). The Resident still saw her when he/she would go upstairs to play bingo and the CNA would give him/her the middle finger. -The Resident reported the CNA's gestures to an activities assistant. -At the conclusion of the interview, the Resident said that he/she did not feel safe. Immediately after the Resident interview, the surveyor informed the Director of Nursing (DON) and Administrator of the allegation. The DON said an investigation of the allegation and a report to Department of Public Health (DPH) would be initiated immediately. During an interview on 5/24/24 at 8:38 A.M., Social Worker (SW) #2 said that she had not been working on this investigation, but that SW #1 had been unable to interview the Resident because he/she had attended activities during the day on 5/22/24 and 5/23/24. SW #2 said the expectation for an allegation of abuse would be that the resident would be interviewed the same day as the allegation was received, and that the interview or attempted interview(s), (if unable to obtain the interview), would be documented in a social work progress note within the resident's clinical record. On 5/24/24 at 10:50 A.M., Resident #30 was observed exiting the elevator onto the third floor. The Resident said he/she had returned from an activity on the second floor where the accused CNA was currently working. The Resident said he/she left the activity because the CNA was giving him/her the finger while he/she was there. The Resident said that until that morning (5/24/24), no staff member had approached him/her to discuss the allegations made to the surveyor on 5/22/24. When asked, the Resident said specifically that no one had approached him/her to speak about his/her concerns with the CNA while at an activity. On 5/24/24 at 11:15 A.M. the surveyor observed an activity occurring in the dining room of the second floor. Review of the investigation data provided by the DON on 5/24/24 at 11:15 A.M. indicated one completed interview with Resident #30. There was no documented evidence of interviews with other residents, staff or visitors provided. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/24/24 at 11:48 A.M., Activity Assistant (AA) #1 said she has worked at the facility for many years as an activities assistant and was familiar with Resident #30. AA #1 said that a couple months ago, when the Resident resided on the second floor, he/she brought a concern about CNA #5 to her. AA #1 said the Resident would not specify the concern and only reported to her that he/she did not like CNA #5 at that time. AA #1 said she brought the Resident down to speak with the former Administrator and former DON and CNA #5 was moved to the fourth floor to work. During an interview on 5/24/24 at 1:46 P.M., the Administrator said that the involved resident should be interviewed right away when allegations of abuse are made. The Administrator further said that the expectation would be that social services would interview all alert and oriented residents on the same assignment about their care relative to the allegation. During an interview on 5/24/24 at 1:57 P.M., SW #2 said that she was given a name for the staff member today (5/24/24) during her interview with the Resident at 9:30 A.M. SW #2 further said the Resident also gave information about the CNA's car to assist in identifying the staff member. During an interview on 5/24/24 at 4:03 P.M., the DON said the Resident should have been interviewed immediately upon identification of the allegation. When asked, the DON said that interviews were being completed now, but that she could not provide any additional evidence of other interviews that had been completed. The DON said that efforts to identify the accused CNA should have been made so the facility could implement measures, such as removing the accused CNA from the schedule, to protect the Resident from the potential for further abuse while the investigation was ongoing.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42741 Based on observation, interview, and record review the facility failed to ensure staff accurately coded Minimum Data Set (MDS) Assessments for three Residents (#9, #50, and #56) out of a total sample of 21 residents. Specifically, 1. For Resident #9 the facility failed to ensure the MDS Assessments were coded accurately related to the use of an anticoagulant medication (medication that thins blood), 2. For Resident #50 the facility failed to ensure the MDS Assessments were coded accurately related to the use of a pressure relieving device (mattress that assists in reducing the likelihood of a resident developing pressure ulcers) on the Resident ' s bed and the use of a restraint., 3. For Resident #56 the facility failed to ensure the MDS Assessments were coded accurately related to the use of an anticoagulant medication. Findings include: 1. Resident #9 was admitted to the facility in October 2020 with a diagnosis of Vascular Dementia. Review of the MDS assessment dated [DATE] indicated the Resident received an anticoagulant medication within seven days of the assessment reference date (ARD-a specific end point for a look back period, utilized to complete a MDS Assessment). Review of the Resident ' s medical record indicated no documentation the Resident had received an anticoagulant medication during the review period for the MDS Assessment. 2. Resident #50 was admitted to the facility in July 2023 with diagnoses of Dementia with Anxiety, Chronic Pain Syndrome, and history of a wound to his/her coccyx (tail bone region of the back). During an observation and interview on 5/22/24 at 8:51 A.M., Nurse #4 and the surveyor observed the Resident to be in bed on a pressure relieving mattress. During the observation Nurse #4 said Resident #50 had been on a pressure relieving mattress since his/her admission as he/she had a history of wounds to his/her coccyx area. Nurse #4 further said she had worked at the facility the entire time Resident #50 had been in the facility and Resident #50 never had any restraints used on him/her. Review of the Residents May 2024 Physician's Orders indicated an order for a therapeutic mattress with a start date of 2/12/24. Review of the Resident's medical record indicated no documentation the Resident had ever utilized a limb restraint while in the facility. (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the MDS assessment dated [DATE] indicated the Resident was not utilizing a pressure reducing device on his/her bed and had a limb restraint during the review period for the 4/24/24 MDS Assessment. 3. Resident #56 was admitted to the facility in August 2023 with diagnoses of Parkinson's Disease, Hypertension, and Peripheral Vascular Disease. Review of the MDS assessment dated [DATE] indicated the Resident received an anticoagulant medication within seven days of the assessment reference date. Further review of the Resident's record indicated no documentation the Resident had received an anticoagulant medication during the review period of the MDS Assessment. During an interview on 5/22/24 at 12:02 P.M., the MDS Nurse said for Resident #9 the 4/6/24 MDS Assessment was coded inaccurately and the Resident was not on an anticoagulant medication, for Resident #50 the 4/24/24 MDS Assessment was coded inaccurately and the Resident was using a pressure reducing device on his/her bed and he/she had never had a limb restraint, and for Resident #56 the 3/29/24 MDS Assessment was coded inaccurately and the Resident was not on an anticoagulant medication. She further said all three of the MDS Assessments needed to be modified to correct the errors.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 42690 Based on record review and interview, the facility failed to provide recommended specialized services from the Preadmission Screening and Resident Review (PASRR- a federal and state-required process that is designed to, among other things, identify evidence of serious mental illness (SMI) and/or intellectual or developmental disabilities (ID/DD) in all individuals (regardless of source of payment) seeking admission to Medicaid- or Medicare-certified nursing facilities) Level II Evaluation (an evaluation conducted to determine if an individual who screened positive for an SMI or ID/DD requires specialized services), for one Resident (#21) out of 21 total residents sampled. Specifically, the facility failed to provide Resident #21 with individual psychotherapy as recommended by the Department of Mental Health (DMH) based on the PASRR Level II Evaluation. Findings include: Resident #21 was admitted to the facility in January 2024 with multiple diagnoses that included Bipolar Disorder (a SMI that causes extreme mood swings, from high to low, that affect your energy, thinking, and behavior). Review of the PASRR Level II Evaluation Determination Summary, completed on 2/26/24, indicated that Resident #21 met SMI criteria for PASRR involvement, and it was recommenced that he/she received individual psychotherapy. Review of the Behavioral Health Group note dated 3/22/24 indicated that Resident #21 is now open to psychotherapy. Further review of the Resident's medical record indicated no documented evidence that Resident #21 received individualized psychotherapy as recommended in the PASRR Level II Evaluation Determination Summary. During an interview on 5/22/24 at 1:24 P.M. Social Worker (SW) #1 said that she was unable to find any notes at this time indicating that the Resident had been seen by anyone for talk therapy since he/she had agreed to receive this service on 3/22/24. SW #1 said that the process is that the team would review the psych recommendations provided by the Physician Assistant through the Behavioral Health Group, put the recommendations in the psych book that is located on each unit, so that the person who provided talk therapy would know to see this Resident. She further said that per the recommendations made by the PASRR Level II Evaluation, the Resident should have been seen by the therapist soon after he/she agreed to the services and was not as required.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 42741 Based on observation, interview, and record review the facility failed to ensure an intervention was implemented as recommended by the Wound Physician's Assistant (PA) for one Resident (#48) out of a total sample of 21 residents. Specifically, the facility failed to ensure a protective boot was obtained for Resident #48 as recommended by the Wound PA to protect the Resident's foot where he/she had a transmetatarsal amputation (TMA-surgical removal of part of the foot). Findings include: Resident #48 was admitted to the facility in January 2023 with diagnoses including Type 2 Diabetes Mellitus, right TMA, and osteomyelitis (a bone infection). During an observation on 5/21/24 at 8:54 A.M., the surveyor observed Resident #48 seated in his/her wheelchair. He/She had a bandage to his/her right foot area, was dangling, and he/she was not wearing a protective boot. During an observation on 5/22/24 from 8:34 A.M. to 9:12 A.M., the surveyor observed Resident #48 to be seated in his/her wheelchair. He/She had a bandage to his/her right foot area and was not wearing a protective boot. During an observation on 5/22/24 at 9:26 A.M., the surveyor observed Resident #48 seated in his/her wheelchair and resting the bandaged area of his/her foot directly on the ground. During an observation on 5/22/24 at 12:43 P.M., the surveyor observed Resident #48 seated in his/her wheelchair and resting the bandaged area of his/her foot directly on the ground. Review of the care plan titled Resident has an actual alternation in skin integrity, right foot TMA, initiated 10/26/23 indicated the following interventions: -Follow Medical Doctor orders for skin care and treatment initiated 10/26/23 -Refer to rehab services as indicated initiated 10/26/23 -Refer to wound care doctor as needed initiated 10/26/23 Review of the 4/26/24, 5/2/24, 5/10/24, and 5/17/24 the facility's contract wound company's Progress notes indicated it had been recommended the Resident was fitted for a Darco Boot (a name brand orthotic boot that is commonly used for post surgical healing, the boot is designed to protect a surgical area from being bumped on surfaces and to reduce weight bearing pressure on a wound). During an interview on 5/22/24 at 12:26 P.M., Nurse #2 said Resident #48 did not have a boot for his/her right foot and nursing was only bandaging the foot daily. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regalcare at Holyoke	282 Cabot Street Holyoke, MA 01040

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/24 at 4:17 P.M., the Regional Rehabilitation Director said she was unaware of the recommendation for the Resident to be fitted with a Darco boot until the surveyor asked about the boot. She said she would expect that nursing would have let the rehabilitation department know of the recommendation for the boot so the rehabilitation staff could start the process of obtaining the boot for the Resident. During an interview on 5/23/24 at 2:45 P.M., with the Wound PA and Medical Director of the wound care company, the Wound PA said an associate from the wound care company made the recommendation for the Darco boot on 4/26/24. She said the Darco boot would provide a protective barrier for the Resident's right foot wound. She further said she would expect the facility would have started the process to obtain the Darco boot within a week of the wound care team's recommendation and the facility had not yet started the process of obtaining the Darco boot as recommended.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 42690 Based on record review an interview the facility failed to ensure one Resident (#12) out of a total of 21 residents sampled received proper treatment and assistive devices to maintain vision abilities. Specifically, for Resident #12 the facility failed to coordinate follow-up services relative to vision, after communicating his/her vision concerns. Findings include: Resident #12 was admitted to the facility in February 2022. Review of the 2/22/24 Minimum Data Set (MDS) Assessment indicated the Resident was cognitively intact as evidenced by a BIMS (Brief Interview for Mental Status) score of 15 out of 15. Review of the Request for Services signed by the Resident on 2/28/22, indicated Eye Care as one of the requested services provided by the mobile contracted agency. During an observation and interview on 5/21/24 at 12:07 P.M., Resident #12 said that he/she had been seen by the eye doctor sometime last July and has not been seen again since. He said that during this visit he/she understood that he/she would be obtaining new glasses to help with his/her worsening vision. The Resident said that he/she cannot see well and would like glasses. The Resident was observed to not be wearing glasses. Review of a Nursing Progress Note dated 12/24/23 indicated the following: -Son informed about need for new glasses and services provided here in that regard. Message left to contact facility after holiday to make arrangements for eye exam and new pair of glasses. Review of the care plan meeting note dated 3/12/24 indicated the following: -Son had concerns with eyeglasses, that he/she (the Resident) needed new ones. During an interview on 5/21/24 at 4:23 P.M. Nurse #3 said that she had never seen the Resident wearing glasses and is unaware of his/her need for new glasses. During a telephone interview on 5/22/24 at 11:06 A.M., Resident #12's son said that about one year ago someone came to the facility and assessed the Resident's eyes. He said that the company who completed the vision assessment said that they would be following up and providing new glasses. The glasses never came, and he said the Resident often talked about how his/her vision being poor and continued difficulty when watching television and reading. He said he and the Resident had both brought it up during care plan meetings and at different times in passing, however, nothing had been done about obtaining the new glasses or a follow up visit at this time. He said that he has even offered to take the Resident out to a provider to obtain the new glasses but was assured by the facility that they had a contract with a company who could see the Resident at the facility. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/24 at 2:04 P.M., Social Worker (SW) #1 said that she was unable to locate any documentation that the Resident had been seen by the contracted vision care agency for the Resident's vision concerns. SW #1 provided a copy of the signed Request for Service form and said that the Resident did wish to have vision care services provided and should have, as requested. During an interview on 5/23/24 at 1:21 P.M., Nurse #3 said that she reviewed the Nursing Progress Note dated 12/24/23 and said that the nurse who wrote the note was a per diem (worked only on an as-needed basis) nurse and did not follow up or do anything with the referral information. She said that nothing had been done and ball had been dropped. During an interview on 5/23/24 at 1:26 P.M., the eye doctor who worked for the contracted agency told the surveyor that he is at the facility monthly and sees the residents that are on the list he is provided.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44129 Based on observations, interviews, and record review, the facility failed to ensure precautions are taken for the resident's individual safety relative to smoking. Specifically, the facility failed to: 1. Ensure fire prevention equipment was readily available in the smoking area to ensure a safe smoking environment. 2. Ensure the smoking plan of care was implemented for two Residents (#82 and #244) out of four applicable residents out of a total of 21 sampled residents relative to resident possession of smoking materials (Resident #82 and #244) and providing a safety intervention (smoking apron) (Resident #244 and #245) assessed to require one. 3. Ensure staff, who accompanied residents outside to smoke, were educated as to what safety interventions to implement in the event of an emergency relative to resident smoking. Findings include: Review of the Department of Health and Human Services Centers for Medicare and Medicaid Services Memorandum titled, Smoking Safety in Long Term Care Facilities, dated 11/10/11 included but was not limited to: - Facilities must include assessment of smoking areas and provision of emergency equipment in the designated smoking areas. - The facility is obligated to ensure the safety of designated smoking areas .the facility is also required to provide portable fire extinguishers in all facilities Review of the facility policy titled Smoking, revised 3/2022, indicated the following: -Smoking is only permitted in designated resident smoking areas, which are located outside of the building. -Metal containers, with self-closing cover devices, are available in smoking areas. - Residents who have independent smoking privileges are not permitted to keep cigarettes, pipes, tobacco, and other smoking articles in their possession. - Residents without independent smoking privileges may not have or keep any smoking articles including cigarettes, tobacco, etc., except when they are under direct supervision. 1. The facility failed to ensure fire prevention equipment such as a fire extinguisher and a fire blanket were readily available to ensure a safe smoking environment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and subsequent interview following a resident smoking break on 5/21/24 between 9:27 A.M. until 9:35 A.M., the surveyor observed Certified Nursing Assistant (CNA) #5 escort three residents (Residents #82, #244, and #245) outside to smoke. The surveyor did not observe any fire prevention equipment in the smoking area such as a fire blanket or fire extinguisher. The surveyor asked CNA #5 what she would do if there was a fire emergency. CNA #5 looked around the area and said, good question. The surveyor asked CNA #5 if there was a fire blanket or fire extinguisher nearby and CNA #5 said there was not. CNA #5 then said she did not know what to do if there were to be a fire that involved one of the residents other than attempt to pat the fire out and yell for help. During an observation and interview on 5/21/24 at 9:40 A.M., the surveyor observed the front entrance to the building, both inside and outside, as well as the main lobby and did not observe fire prevention equipment. The surveyor asked the receptionist if there were any fire extinguishing materials behind her desk or anywhere in the lobby and she said there were not. During an interview on 5/22/24 at 3:35 P.M., the Regional Director of Operations said there was not a fire extinguisher located in the vicinity of the designated smoking area. 2. The facility failed to implement the smoking plan of care for two Residents related to possession of smoking materials (Resident #82 and #244) and applying a protective smoking apron to two Residents assessed to need one (Resident #244 and #245) During an observation of resident smoking and a concurrent interview on 5/21/24 from 9:27 A.M. until 9:35 A.M., the surveyor observed three Residents (#82, #244, and #245) outside smoking accompanied by CNA #5. The surveyor asked CNA #5 if the residents were allowed to keep their cigarettes on their person or if they were required to have their smoking paraphernalia locked up on the unit. CNA #5 said Resident #82 and Resident #245 had permission to keep cigarettes in their possession, but Resident #244 was not allowed to keep cigarettes in his/her possession. At that time, Resident #244 spoke up and said he/she kept his/her cigarettes in his/her possession because, they trust me with them. 2a. Resident #82 was admitted to the facility in October 2023 with a diagnosis of Dementia. Review of the Resident's most recent Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of a possible 15. Further review of the MDS assessment indicated the Resident was able to make him/herself understood and understood others. Review of the Resident's Smoking Safety Screen dated 10/13/23 indicated the Resident was a smoker, required supervision, and that the Resident required the facility to store lighter and cigarettes. Review of the Resident's Smoking Care Plan dated 10/24/23 and revised on 5/6/24 indicated the Resident required supervised smoking, smoking materials were to be stored in a secured area and the smoking policy was to be reviewed with the Resident and/or his/her health care representative. During an observation and interview on 5/21/24 at 9:11 A.M., the surveyor observed Resident #82 seated in his/her wheelchair on the nursing unit waiting for a staff member to take him/her outside to smoke. Resident #82 said he/she goes outside approximately three times per day, depending on when staff were available to take him/her outside. Resident #82 then said that he/she keeps his/her cigarettes with him/her pointing to a small, zippered bag next to him/her on the wheelchair, and that staff trust him/her to keep the cigarettes with him/her. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 5/23/24 at 9:05 A.M., Resident #82 said he/she was waiting to go outside to smoke and opened his/her zippered bag next to him/her on his/her wheelchair and showed the surveyor a pack of cigarettes in his/her bag. During an observation of resident smoking on 5/23/24 from 10:05 A.M. until 10:35 A.M., the surveyor observed Resident #82, with the assistance of the Activity Director, remove a cigarette from a pack of cigarettes Resident #82 removed from his/her zippered bag, and the Activity Director assisted the Resident in lighting his/her cigarette. 2b. Resident #244 was admitted to the facility in May 2024 with diagnoses including: Fractured Femur, Chronic Obstructive Pulmonary Disease (COPD, a group of diseases that block airflow and make it difficult to breathe), and Dementia. Review of the Nursing Admission assessment dated [DATE] indicated the Resident was oriented to person, place, and time. Review of the Resident's Smoking Evaluation dated 5/13/24 indicated the Resident was a smoker, required supervision and smoking materials were to be stored by the facility. Review of the Resident's Smoking Care Plan dated 5/10/24 and revised on 5/17/24 indicated the Resident required supervised smoking and was to wear a smoking apron while smoking. During an observation of resident smoking on 5/21/24 from 9:27 A.M. until 9:35 A.M., the surveyor observed the Resident smoking without a smoking apron. During an observation on 5/23/24 at 9:50 A.M., the Resident showed surveyor a pack of cigarettes he/she keeps in his/her nightstand and said he/she was allowed to keep them because they trusted him/her. During an observation of resident smoking on 5/23/24 from 10:05 A.M. until 10:35 A.M., the surveyor observed the Resident to be smoking without a smoking apron. 2c. Resident #245 was admitted to the facility in May 2024 with a diagnosis of Acute Respiratory Failure. Review of the Resident's Nursing Admission Evaluation dated 5/14/24 indicated Resident was alert, followed commands, and had both short- and long-term memory loss. Further review of the Nursing Admission Evaluation dated 5/14/24 indicated the Resident was a smoker, required supervision, required the use of a smoking apron and smoking materials were to be stored by the facility. Review of the Resident's Smoking Care Plan dated 5/15/24 and revised on 5/16/24 indicated the Resident required supervised smoking and was to wear a smoking apron while smoking. During an observation of resident smoking on 5/21/24 from 9:27 A.M. until 9:35 A.M., the surveyor observed the Resident smoking without a smoking apron. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/24 at 2:55 P.M., CNA #5 said that smoking aprons were a new thing at the facility, they have not used them in the past and that they were on order for the residents who need them. During an interview on 5/22/24 at 4:00 P.M., CNA #6 said he often brings residents outside to smoke, smoking aprons were not available until yesterday and residents were not allowed to keep smoking materials in their possession due to safety concerns. During an interview on 5/23/24 at 8:00 A.M., the Director of Nursing (DON) said for the longest time the facility did not really have many smokers, however there are now several residents who smoke. The DON said there were currently residents whose care plans indicated a need for smoking aprons for safety, however the facility did not have any smoking aprons on hand. During an observation of resident smoking on 5/23/24 from 10:05 A.M. until 10:35 A.M., the surveyor observed the Activity Director place a smoking apron on Resident #245. Directly after the Activity Director placed the smoking apron on Resident #245, the Resident told the surveyor this was the first time he/she ever wore a smoking apron. During an interview concurrent with resident smoking on 5/23/24 from 10:05 A.M. until 10:35 A.M., CNA #4 said there have not been many residents who were smokers in the building until very recently. CNA #4 said there was no system in place to ensure the residents' smoking materials were secured as well as ensuring smoking aprons were provided as needed, and up until now, there were no smoking aprons, no fire blankets, and no fire extinguisher available to staff who take the residents out to smoke. CNA #4 further said there should be a process in place to ensure resident safety and there was none. CNA #4 also said if a resident required a smoking apron, that information should be available to CNAs in the resident's care plan, so the CNAs know which residents required them, and the reason he placed a smoking apron on Resident #245 was because he knew the Resident once burned a hole in his/her pants while smoking at the facility. CNA #4 said that no resident was allowed to keep smoking materials on their person or in their rooms, and they were supposed to be secured by the nursing staff. 3. During an interview on 5/23/24 at 1:40 P.M. Unit Manager (UM) #1 said education provided to facility staff regarding the resident smoking process and safety was ongoing, however no formal education was provided by the Staff Development Coordinator. During an interview on 5/23/24 at 1:55 P.M., CNA #7 said she takes residents outside to smoke occasionally and has not received any education related to the resident smoking process and smoking safety. During an interview on 05/23/24 at 2:25 P.M., CNA #4 said he takes residents outside to smoke regularly and has not received any education related to the resident smoking process and smoking safety. During an interview on 5/24/24 at 8:47 A.M., CNA #5 said she takes residents out to smoke regularly and has not received any education related to the resident smoking process and smoking safety. CNA #5 said she had never given it any thought until the surveyor asked her what she would do if a resident ignited him/herself. See F926

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 45435 Based on record review, policy review and interview, the facility failed to provide care and services consistent with professional standards for one Resident (#1) out of one applicable resident, out of a total sample of 21 residents. Specifically, the facility staff failed to coordinate delivery of medications with Resident #1's dialysis (procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) treatment schedule to ensure the Resident received all medication as ordered by the Physician. Findings include: Review of the facility's policy titled Care of a Resident with End Stage Renal Disease (ESRD-a permanent stage of chronic kidney disease that occurs when the kidneys can no longer function on their own requiring dialysis or a kidney transplant), dated 4/2022 indicated the following: -Staff caring for residents with End Stage Renal Disease, including residents receiving dialysis outside the facility, shall be trained in the care and special needs of these residents. -Education and training of staff includes, specifically: Timing and administration of medications, particularly those before and after dialysis. Resident #1 was admitted to the facility in August 2023 with a diagnosis of ESRD. Review of the medical record indicated the Resident received Dialysis treatments every Monday, Wednesday and Friday at an off-site Dialysis center. Review of the Physician's Orders dated May 2024 indicated the following orders: -Gabapentin (a medication used to treat seizures or nerve pain) 100 milligrams (mg) give one time daily related to diabetic neuropathy (a type of nerve damage), date initiated 10/5/23. -Acetaminophen (a medication used to treat mild or chronic pain) 975 mg by mouth every eight hours related to low back pain, date initiated, 3/3/23. -Hydralazine (a medication used to treat high blood pressure) 100 mg three times a day for hypertensive urgency (high blood pressure), date initiated 3/4/23. -Vistaril (a medication used to treat anxiety, nausea, allergies, and itching) 25 mg three times a day for itching, date initiated 4/26/24. Review of the Medication Administration Record (MAR) dated May 2024, indicated the following: -Gabapentin 100 mg was scheduled to be administered daily at 2:00 P.M. -Acetaminophen 975 mg was scheduled to be administered daily at 6:00 A.M., 2:00 P.M, and 10:00 P.M. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Hydralazine 100 mg was scheduled to be administered daily at 9:00 A.M., 1:00 P.M., and 5:00 P.M. -Vistaril 25 mg was scheduled to be administered daily at 9:00 A.M., 1:00 P.M., and 5:00 P.M. Review of the MAR dated 5/1/24 through 5/22/24 indicated the Resident did not receive the following medications on 5/1/24, 5/3/24, 5/6/24, 5/8/24, 5/10/24, 5/13/24, 5/15/24, 5/17/24, 5/20/24 and 5/22/24 due to the Resident being at dialysis: - Gabapentin 100 mg at 2:00 P.M, -Acetaminophen 975 mg at 2:00 P.M., -Hydralazine 100 mg at 1:00 P.M., and -Vistaril 25 mg at 1:00 P.M. During an interview on 5/22/24 at 9:50 A.M., Nurse #2 said the Resident goes to dialysis on Monday, Wednesday and Friday and on those days, he charts the 1:00 P.M. and 2:00 P.M. medications as not given-absent from building. He says he does not send any medication to the dialysis center with the Resident, but he believes that the medications were administered at the dialysis center. During an interview on 5/22/24 at 1:03 P.M., Nurse #2 said he had called the dialysis center and found out the dialysis center does not administer the Resident his/her scheduled medications prescribed at the facility, and that the Resident has not been getting his/her scheduled 1:00 P.M. and 2:00 P.M. medications as ordered by the Physician on dialysis days. During an interview on 5/22/24 at 3:33 P.M., the Director of Nurses says the prescribed medications should not have been omitted on dialysis days and the medication administration times should have been adjusted.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 50563 Based observations, interviews, policy and record review the facility failed to ensure that there was sufficient nursing staff to assist residents in attaining and maintaining the highest practicable physical, mental, and psycho-social well-being on three (Unit Two, Unit Three and Unit Four) out of three observed units. Specifically, the facility failed to: 1)Ensure sufficient staff as determined by the Facility Assessment 2)Ensure call bells were responded to timely for Residents #83 & Resident #22 Findings include: Review of the facility policy titled Emergency Staffing Strategies, dated September 2020, indicated but was no limited to the following: -In the event that sufficient staff is not available from the individual SNF's (Skilled Nursing Facility) workforce, the facilities incident commander shall coordinate other available corporate resources to obtain additional employees from other facilities to staff the stricken facilities during emergencies and disasters. -Assign ancillary staff who possess Registered Nurse (RN)/Licensed Practical Nurse (LPN)/Certified Nurse Aide (CNA) license to work on units for direct care 1) Review of the Facility Assessment (an assessment completed by the facility to identify what resources are necessary for competent care of residents on a day-to-day or emergency basis), dated 4/17/24, indicated but was not limited to: -Direct care staff CNA or Licensed Nurse providing Activity of Daily Living (ADL- self-care activities like bathing, dressing, eating) care to residents for the day ratio should be the following to meet the resident needs: > 1:10 (number of direct care staff to number of residents) on the Day shift (7:00 A.M.- 3:00 P.M.), >1:11 on the Evening shift (3:00 P.M.-11:00 P.M.), and >1:17 on the Night shift (11:00 P.M.- 7:00 A.M) Review of actual worked nursing schedules with daily unit census data (number or residents residing on a given unit on a given day) from 4/19/24 through 5/19/24 indicated the following: -Unit Two: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	> Day Shift Staffing Ratios had one day greater than the ratio per the Facility Assessment of 1:10 on 5/3/24 (1:16). >Evening Shift Staffing Ratios were greater than the 1:11 ratio on six days; 4/19/24, 4/20/24, 4/22/24, 5/2/24, 5/13/24, 5/14/24, and 5/18/24 (ratios ranged from 1:11.5 to 1:14.7). -Unit Three: >Day Shift Staffing Ratios were greater than the 1:10 ratio on 18 days; 4/19/24 through 4/25/24, 4/27/24 through 5/3/24, 5/11/24, 5/13/24, 5/18/24 and 5/19/24(ratios ranged from: 1:10.7 to 1:17) > Evening Shift Staffing Ratios were greater than the 1:11 ratio on 2 days; 5/1/24 and 5/14/24 (ratios ranged from 1:13.6 to 1:33) -Unit Four: > Day Shift Staffing Ratios were greater than the 1:10 ratio on 6 days; 4/20/24, 4/21/24, 4/23/24, 4/28/24, 5/18/24 and 5/19/24 (ratios ranged from 1:10.7 to 1:15) > Evening Shift Staffing Ratios were greater than the 1:11 ratio on 2 days; on 4/20/24 and 4/24/24 (ratio of 1:12.8) 2) On 5/21/24 from 9:46 A.M. until 9:51 A.M., the surveyor observed the following on Unit Four: -Resident #83's call bell light to be on -Call bell system located at the nurses indicated Resident #83's call bell light had been on for 13 minutes -Surveyor went to the Resident's room to inquire about the call bell wait time. Upon arriving to Resident #83's room, the surveyor found the Resident to be at the doorway, holding a soiled hospital gown, wearing a brief with feces coming out of the brief, onto his/her leg and on the wheelchair. -Resident said that he/she had trouble controlling his/her bowels and needed help getting cleaned up. The Resident thought his/her call bell light was not working because no one had come to see what he/she needed. Resident #83 said that because he/she thought the light was not working, he/she would go to the bathroom to pull the bathroom cord, hoping that would work. -9:47 A.M. bathroom light on and flashing red -9:48 A.M. Resident calling out hello from the bathroom. -9:51 A.M. CNA entered the bathroom to assisted Resident #83 -In total, the Resident waited 18 minutes for facility staff to provide assistance (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3) On 5/22/24, the surveyor conducted a Resident Council Meeting with 11 residents. Of the 11 residents who were present, 10 actively participated in the meeting and resided Units 3 and 4. The following concerns were identified by the participating residents: -four residents said that there were long wait times for call bells due to low levels of staffing. -One resident specified at times the wait had been over a hour for the call bell to be answered. -One resident said that there was only two CNAs sometimes for 18 rooms that mostly house 2 residents per room, and it is not enough staff. -One resident said there are frequent call outs that leave them with 2 CNAs on a unit. 4) During an interview on 5/21/24 at 4:24 P.M., Nurse #3 said that today, on the 4th floor the staff worked the entire shift down two (CNA's). She said it was difficult, but the team worked together to get through the day to provide care for the residents. She said that she spent much of her day near the nurse's station and the dining room because they have multiple residents who are fall risks. During an interview on 5/22/24 at 7:30 A.M., Nurse #3 said that there were currently two Nurses and two CNA's. She said that there were four CNAs scheduled, one called out, one would be coming in at 7:30 A.M., and that two CNAs came in at 7:00 A.M. She said there were call outs on all three units today. During an interview on 5/22/24 at 3:13 P.M., CNA #13 said she worked at the facility 40 hours a week for several years on Unit Four. CNA #13 said it is hard to complete the assignments if the unit was short (2 CNAs for the unit) and residents sometimes have had to stay in bed because they don't have enough time to care for them. CNA #13 said that the facility considers Unit 4 fully staffed at 3 CNAs, but 4 CNAs are needed to properly care for the residents, many of whom were dependent on staff and use mechanical lifts (a machine that requires two qualified staff members to operate to lift a resident to transfer them to and from the bed and chair) to get them out of bed. During an interview on 5/22/24 at 4:04 P.M., CNA # 14 said that there were times the unit has been left with one CNA for the evening shift which can leave one staff member responsible for all the care of 29 residents or more. CNA #14 said it was extremely hard to provide the care the residents need with one CNA on the unit. During an interview on 5/22/24 at 4:20 P.M. CNA # 11 said she was a regular staff member for evening shift and work mostly on Unit Three and Unit Four. CNA #11 said they have typically worked with two CNAs on a unit once or twice a week. CNA #11 further said that call outs often left them short staffed and there was no plan or replacements for staff who called out. CNA #11 said when there was only two CNAs on a unit, nurses did not help, and the two CNAs were responsible for all the resident care, meal passes, assistance with eating and answering call bells for the residents. During an interview on 5/23/24 at 6:45 A.M. CNA #10 said she had worked at the facility for many years on Unit Four. CNA #10 said that night shift was usually staffed with two CNAs but that on occasions they have worked with only one CNA for the unit but that was not typical. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/23/24 at 6:59 A.M. CNA #9 said she was a regular staff member that had worked several years at the facility on Unit Three. CNA #9 said sometimes they work alone on night shift (as the only CNA for the unit) but that staffing on day shift was always bad causing night shift staff to have to unexpectedly stay late when relief didn't arrive or came in late. CNA #9 further said that Unit Three often had two CNAs on day and evening shift. CNA #9 said that short staffing caused her to not be able to take care of residents the way she wanted or should and it was frustrating. During an interview on 5/23/24 at 7:09 A.M. CNA #8 said she typically worked on Unit Two but sometimes worked Unit Three. CNA #8 said they typically have two to three CNAs for Unit Three but when they have two it is hard to provide care to the residents due to the workload. During an interview on 5/23/24 at 8:27 A.M., the Administrator said they currently did not have a staffing coordinator for the last week or two but had hired someone who had not started yet, and the Assistant Director of Nursing (ADON) was currently overseeing staffing for nursing staff on the units. The Administrator said that they had agency contracts in place, but they did not use agency staff at all since she had been there (started in the beginning of May). When asked for contingency staffing plan, the Administrator indicated the Emergency Staffing Strategies policy would be utilized. 5) During an observation and interview on Unit Three on 5/23/24 at 10:22 A.M., the surveyor heard the call bell system ringing at the nurse's station for Resident #22. The surveyor went to the Resident's room, observed the call bell light to be on at the Resident's door, and the Resident (who was in the room) said he/she had been waiting a long time and just wanted to have his/her radio plugged in and turned on. During an interview and observation on 5/23/24 at 10:28 A.M., directly following the surveyor's interaction with the Resident #22, the surveyor and Nurse #2 observed the call bell system at the nurse's station indicated the call bell in Resident #22's room had been on for 82 minutes. Nurse #2 said the call bell system at the nurse's station starts when the call bell system is activated in a resident's room and tracks how long the call light is on for. He said currently on Unit Three there was only two CNAs, and this was not enough CNAs on the Unit to meet the needs of the residents and to answer call bell lights timely. He further said the Unit needed three CNAs for the resident's needs to be met and that initially at the beginning of the day the Unit only had one CNA until a CNA from another unit came to assist. 6) During an interview on 5/23/24 at 10:52 A.M. the ADON said she did not know when she took over staffing the facility but believed it was in the beginning of April. The ADON said prior to taking over she had not been involved with staffing. The ADON said that on day shift Units Two and Three should have three CNAs and Unit Four should have four, on evening shift Unit Two should have two CNAS, Unit Three should have three CNAs and Unit Four should have four CNAs, and on night shift all three units should have 2 CNAs. The ADON said this staffing pattern was based off of census and the acuity (need level) of the residents on each unit. The ADON sad that she had heard from staff almost weekly that they were frustrated when they had to work short due to call outs. The ADON said that the Director of Nursing, Unit Manager and Infection Control Nurse were all hands on with the schedule but that there were still issues with staffing and that staffing issues would cause problems with everything including meals and call bell response times. Relative to call bell wait times the ADON said that her expectation would be no more than 15 minutes at the longest to wait but would more likely be five to ten minutes for someone to respond. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/23/24 at 2:13 P.M., Nurse Practitioner (NP) #1 said that it had been frustrating to ensure follow up appointments and referrals were completed. She said that there seemed to be a communication breakdown maybe due to lack of consistent staff, staff being per diem and not having enough staff. She said that the NP's try to follow up on referrals and recommendations that have made but do not always have time to do so and that the NP's relied on the staff to ensure the orders and referrals are being carried out.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50563 Based on interviews, record review and review of the Facility Assessment (an assessment completed by the facility to identify what resources are necessary for competent care of residents on a day-to-day or emergency basis), the facility failed to ensure annual performance appraisals for Certified Nurse Aides (CNAs) were completed every 12 months. Specifically, the facility failed to ensure that two CNAs (#4 and #5) out of 2 applicable CNAs reviewed had an annual performance appraisal completed and ensured regular in-service education was completed based on the result of the performance appraisals. Findings include: Review of the Facility Assessment, dated 4/17/24, indicated no documented evidence the facility addressed the need for annual performance appraisals of CNAs. CNA #4 was hired to the facility on [DATE]. A review of CNA #4's Human Resource (HR) record indicated no documented evidence that performance appraisal(s) had occurred. CNA #5 was hired to the facility on [DATE]. A review of CNA #5's HR record indicated no documented evidence that performance appraisal(s) had occurred. During an interview on 5/24/24 at 2:14 P.M., the Infection Control Nurse/Staff Development Coordinator (ICP/SDC) indicated that performance appraisals should occur annually for staff and that the Director of Nursing or Unit Manager would be the person(s) responsible for completing nursing staff performance appraisals. ICP/SDC said that CNA #4 and CNA #5 should have had annual performance appraisals completed. During an interview on 5/24/24 at 3:21 P.M., the Regional Consultant Nurse #1 said that the facility could not produce evidence that performance appraisals had occurred for CNA #4 and CNA #5. The Regional Consultant Nurse #1 further said that the Administrator and DON were new and would not be able to answer for previous practice, and that the performance appraisals should have been completed annually and would be kept in the employee's HR records. During an interview on 5/24/24 at 5:00 P.M., the Administrator stated the facility did not have a policy for performance appraisals.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. 45435 Based on record review and interview, the facility failed to provide the necessary Behavioral Health care and services to attain or maintain the highest practicable mental, and psychosocial well-being for one Resident (#56), out of a total sample of 21 residents. Specifically, the facility staff failed to provide Behavioral Health Services for Resident #56 when he/she displayed symptoms of Depression (a common and serious mood disorder that may include symptoms of fatigue, sleep and appetite disturbances, agitation, and expressions of guilt, difficulty concentrating, apathy, withdrawal, and suicidal ideation). Findings include: Resident #56 was admitted to the facility in August 2023 with diagnoses that include Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors) and Depression. Review of the Minimum Data Set (MDS) Assessment, dated 3/29/24, indicated the Resident had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) exam score of 10 out of a possible 15, and took antidepressant medication. Review of the Physician's Orders dated 5/23/24 indicated the following: -Sertraline (an antidepressant used to treat the symptoms of depression) 50 milligrams (mg) one time daily for depression, date initiated 8/30/23. Review of the Request for Service form dated 12/21/23, indicated the Resident Representative had provided consent for Behavioral Health Services. Review of the Interdisciplinary Progress Note, dated 4/10/24, indicated the Resident's Health Care Proxy shared concerns for the Resident's depression. The note further indicated the Resident would be seen by Psychiatric services. Review of the Care Plan Meeting Note, dated 4/10/24, indicated the Resident's sister reported the Resident was more down lately, almost depressed. The note further indicated the Resident would be seen by Psychiatric services. Further review of the clinical record indicated no documented evidence the Resident was provided Behavioral Health Services. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/24 at 1:48 P.M., Social Worker (SW) #1 said the process for signing a resident up for Behavioral Health Services was to obtain consent, and then put the resident's name and the reason for the referral in the Behavioral Health book located in the Social Services office. She reviewed the book and said that she did not see a referral for Resident #56. She said Behavioral Health providers come to the facility about once a week, they review the book, and if a new resident was added, they will initiate services. She said Resident #56 had a consent on file but that she had no evidence that Behavioral Health services had been offered.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50563 Based on observations, interviews, and test tray results, the facility failed to serve palatable food at an appetizing temperature, to all residents, on three Units (Unit Two, Unit Three, and Unit Four) of three units observed as well as in the Main Dining Room. Findings include: On 5/22/24, the surveyor conducted a Resident Council Meeting with 11 residents. Of the 11 residents who were present, 10 actively participated in the meeting and resided Units Three and Four. The following concerns were identified by the participating residents: -Two residents said the food was always cold -One resident said the food was bland but otherwise is good -One resident said the food was either too bland or had too much salt -One resident agreed the food was salty, specifically that the gravy was salty During the initial walkthrough on 5/21/24 at 10:15 A.M., the surveyor received the following comments from two residents on Unit Two: -The food is cold and is never hot enough. -The food is always cold. I don't think they cook it right or they need heat boxes. 1. On 5/23/24 from 11:43 A.M. to 12:06 P.M., the surveyor observed meal tray pass on Unit Three. -At 11:43 A.M. the first meal cart was delivered to the unit. -At 11:45 A.M. Nurse #2 and an activities assistant began passing trays from the first meal cart. -At 11:49 A.M. the second meal cart was delivered to the unit. A second nurse joined Nurse #2 and the activities assistant in passing trays. -At 11:51 A.M. Regional Consultant Nurse #1 and a second Regional Consultant Nurse arrived to the unit and began to assist the two nurses and activities assistant with passing trays. -At 11:54 A.M. staff began passing trays from the second meal cart. -At 12:06 P.M. the last tray was passed from the second meal cart and tray pass was complete. On 5/23/24 at 12:06 P.M. Regional Consultant Nurse #1 took temperatures of the food on the Unit Three test tray and beverages with the surveyor as follows: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Hamburger macaroni: 108 degrees Fahrenheit (F) -Cooked carrots: 90 degrees F -Banana cream pie: 70 degrees F -Milk: 52 degrees F At 12:10 P.M. the surveyor tasted the test tray: -Hamburger macaroni: mixed temperature throughout, some areas warm, others cold to taste -Cooked carrots: lukewarm to taste -Banana cream pie: lukewarm to taste -Milk: cool to taste 44129 2. On 5/23/24 at 11:55 A.M. on Unit Two, the surveyor along with Unit Manager #1 obtained temperatures from the lunch test tray. The temperatures were as follows: - Sliced carrots, 90 degrees F - cool to taste - Cheesburger macaroni, 119 degrees F in the center, however there were areas of warm mixed with very cool temperatures. 42690 3. On 5/23/24 from 11:31 A.M. to 11:56 A.M., the surveyor observed the lunch service in the main dining room. At 11:56 A.M., the Food Service Director (FSD) and the surveyor obtained the temperature and tasted each item, and observed the following: -Cheeseburger macaroni- 155 degrees F -Steamed carrots- 128.4 degrees F -Roll - 76 degrees F The FSD and surveyor each tasted the cheeseburger macaroni and steamed carrots. The FSD said that both were lukewarm to taste. He said that it was hard maintain the temperature with the Styrofoam trays that the food was being served on today. He said they were serving the food on Styrofoam take out containers today due to the boiler that the kitchen runs off being down. 42741 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 5/23/24 from 11:55 A.M. to 12:10 P.M., the surveyor observed the following on Unit Four: -11:55 A.M., the 2nd meal cart arrived on Unit Four, the 1st meal cart was already on the unit, but no trays had been passed from the 1st meal cart. -From 11:55 A.M. to 12:01 P.M., trays were passed from the 2nd meal cart -From 12:01 P.M. to 12:10 P.M., trays were passed from the 1st meal cart -12:10 P.M., the surveyor received the test tray which came up on the 2nd meal cart At 12:10 P.M., Nurse #5 and the Regional Consultant Nurse obtained temperature of the food on the test tray, the surveyor tasted each item, and the following was observed: -Pureed Pork with gravy- 82 degrees F, cool to taste and was very salty -Mashed Potatoes with gravy- 78 degrees F cool to taste -Pureed Carrots- 72 degrees F cold to taste and liquid in consistency -Chocolate pudding- 64 degrees F cool to taste but not cold -Carton of milk- 60 degrees F cool to taste but not cold During an interview following the test tray observation Nurse #5 said he was unsure what the temperature of the food should be when it was served to the residents. During an interview on 5/23/24 at 2:00 P.M., the FSD said hot food should arrive hot and cold foods should arrive cold to the units. When discussing the temperatures taken during the test trays on the units the FSD said food coming up from the kitchen to the units should change no more than 5-6 degrees F by the time it is served to the residents and should be a palatable temperature.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42741 Based on observation and interview the facility failed to ensure two Unit (Unit #3 and Unit #4) kitchenettes were maintained in a clean and sanitary manner out of three Unit kitchenettes observed. Findings include: Review of the facility policy titled Food Brought Into Facility, revised 5/22, indicated the following: -Perishable foods must be stored and identified with the resident ' s name, food item, and use by date. These can be stored in the nursing unit kitchen nourishment refrigerator. Review of the Daily Checklist for Dietary Cleanliness, undated, provided by the Food Service Director (FSD), indicated the following: -Make sure Unit Kitchens are stocked, cleaned, and rotated all shifts. This includes Microwave, Refrigerators, Toaster, etc. Unit Three During an observation on 5/21/24 at 8:47 A.M., in the Unit Three Kitchenette the following was observed: -Toaster crumb drawer laden with crumbs and toaster had burnt on material inside. -Frozen item in kitchenette freezer dated 6/1/24 with no name. During an observation on 5/22/24 at 12:38 P.M., in the Unit Three kitchenette the following was observed: -Toaster crumb drawer laden with crumbs and toaster had burnt on material inside. -Frozen item in kitchenette freezer dated 6/1/24 with no name. During an observation and interview on 5/22/24 at 12:53 P.M., Nurse #1 and the surveyor observed the Unit Three Kitchenette. Nurse #1 said it did not appear the toaster was cleaned regularly and having excess crumbs in the toaster was a fire risk. Additionally, Nurse #1 said all food items placed in the freezer should be labeled with the date the item was brought in and a resident ' s name and she was unsure who the item in the freezer belonged to or when it was placed in the freezer. Nurse #1 also said she was unsure whose responsibility it was to clean the kitchenette or how often it was cleaned. Unit Four (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 5/22/24 at 2:50 P.M., Nurse #3 and the surveyor observed the Unit Four kitchenette and the following was observed: -Toaster crumb drawer was laden with crumbs and large chunks of toasted were in the bottom of the toaster. Nurse #3 said the kitchenettes should be cleaned daily by the kitchen staff in the morning. She further said that amount of dried bread in the toaster was a fire risk. During an interview on 5/23/24 at 10:48 A.M., the surveyor showed the FSD the photos of the toasters on Unit Three and Unit Four and of the freezer item that was dated 6/1/24. The FSD said the kitchenettes should be cleaned daily and daily cleaning included the toasters. He said the toasters did not appear that they had been cleaned recently. The FSD further said items in the freezer should be dated with the date the food was brought in so it could be discarded after three days, and he was unsure why an item was dated 6/1/24. He said with out a proper date and name he could not be sure who the item belonged to and how long it had been in the freezer.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42690 Based on record review and interviews, the facility failed to provide specialized rehabilitation services for one Resident (#78) out of 21 total residents sampled. Specifically, for Resident #78 the facility failed to obtain specialized services relative to speech-language pathology for a Resident experiencing ongoing difficulty swallowing putting him/her at an increased risk of experiencing an adverse effect such as aspiration pneumonia (a type of lung infection that is due to a relatively large amount of material from the stomach or mouth entering the lungs) or choking. Findings include: Review of the Facility assessment dated [DATE] indicated the facility will provide Speech/language services based on the Resident's needs. Resident #78 was admitted to the facility in June 2023 and had the following diagnoses: of GERD (gastro-esophageal reflux disease, a condition that causes heartburn or acid indigestion) and Dysphagia (difficulty in swallowing food or liquid). Review of the 3/13/24 Minimum Data Set (MDS) Assessment indicated the Resident was cognitively intact as evidenced by a BIMS (Brief Interview for Mental Status) score of 14 out of 15. Review of the Physician's Order Summary Report as of 5/33/24, indicated an order for Speech Therapy to evaluate and treat as indicated, initiated on 6/8/23. Review of a dietary note dated 12/12/23 indicated the following: -Resident reports incomplete swallow, coughing with eating, feeling raspy crumbs in throat. -Kitchen, SLP (Speech and Language Pathologist) and NP (Nurse Practitioner) notified. Review of the NP encounter note dated 12/13/23 indicated the following: -Seen today regarding staff noting recent cough with meals. -Will request speech to evaluate and treat. -He/she stated he/she coughed when eating and drinking -He/she stated, it gets stuck and comes up mucous. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/22/23 at 2:00 P.M., the Director of Rehabilitation reviewed the Resident's medical record and said that she did not have any SLP notes available and further said that it did not appear that Resident #78 had been seen by a SLP. She further said that the referral process was for nursing staff to complete a therapy communication form that should be located on each unit and then brought to morning meeting each day. She said that if the therapy communication form was not brought to morning meeting and given directly to the Director of Rehabilitation, the completed form could be left in the bin outside of the rehabilitation gym door. The Director of Rehabilitation said that she had no evidence of receiving a referral for Resident #78 to be seen by the SLP. She further explained that the SLP worked full time at another facility but came in as needed. During an interview on 5/23/24 at 1:31 P.M., Nurse #3 said that the Resident continued to have swallowing concerns that included difficulty swallowing, feeling like food is too hard and increased mucus. She said that these concerns had been identified by both the Dietician and the NP in December 2023, both with recommendations to be seen by the SLP. She said that the referral had never been communicated therefore the Resident was never seen by the SLP, placing him/her at risk for an adverse situation to occur such as aspiration pneumonia or choking, due to his/her difficulty swallowing. Nurse #3 said that the referral should have been communicated back when it was first acknowledged that the Resident was having difficulty swallowing and was not. She further said there was a lack of communication and the referral fell through the cracks. During an interview on 5/23/24 at 2:13 P.M., NP #1 said when she made a referral or had a new order, she would write it down on a progress note, verbally communicate with nursing, review the handwritten progress note and the receiving nurse would then sign off acknowledging that the referral, recommendation and/or new order was received. She further said she could not speak to why the referral had not been completed for Resident #78.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 37400 Based on observations and interviews, the facility failed to ensure Administration and/or the Governing Body provided residents in the facility with appropriate care and services in order to maintain their highest practicable physical, mental, and psychosocial well-being. The facility failed to identify and implement plans to address numerous facility wide concerns, failed to fully assess the facility staffing needs in order to meet resident needs, and failed to ensure supplies for resident care were available and accessible. Findings include: During the re-certification survey conducted by the survey team from 5/21/24 through 5/24/24, the following concerns were identified by residents/resident representatives and staff: -resident supplies including incontinence briefs, washcloths or towels, and clothes were not always available 1. Review of the Facility Assessment, dated 4/17/24, indicated the facility accepts residents with a broad range of diseases and disabilities primarily including common diseases of the elderly for its long-term care unit. These conditions, physical and cognitive disabilities, or combinations of conditions require complex medical care and management and included: -urinary incontinence 2. On 5/22/24 at 10:32 A.M., the surveyor conducted a resident council meeting and 11 residents were present. One resident who was present did not participate. The following concerns were discussed: -One resident said they don't have enough incontinence briefs sized extra large -Two other residents said the facility does not have medium size incontinence briefs and that they had to purchase their own. -One resident said that facility staff recommended that he/she drink less so he/she does not need so many incontinence briefs -Four residents said they do not have enough soup, one of the resident said he/she has family bring in soap and has loaned it to facility staff to use on other residents because there is none. -One resident said that CNAs have purchased soap to use on the residents due to not having any. -One resident reported that he/she took a shower and the towel he/she used was thread bare and had holes in it. -One resident said the CNAs have cut up old towels to use as face clothes. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/24 at 3:13 P.M., CNA #13, who has worked on Unit Four, said they are short on incontinence briefs for residents and are currently using small incontinent briefs for residents who need large incontinence briefs. CNA #13 said this has been going occurring on/off for a long time. She said there is never have enough linen-specifically towels, wash cloths and the amount available varies. Sometimes when the CNAs ask for supplies and don't get it, they have to go downstairs (where the laundry room is located) to get linens, towels and face clothes and there isn't enough to take. CNA #13 said there isn't always soap available to use for the residents and sometimes she and other CNAs have had to bring their own soap to provide care. She said sometimes they have had to borrow from other residents family supplied soap because it was the only option to get residents washed. During an interview on 5/22/24 at 3:29 P.M., CNA #12 said sometimes they run out of incontinence briefs for residents. On 5/22/24 at 3:56 P.M., the surveyors observed the Unit Three clean utility room. There were minimal towels and washcloths available and one sized brief observed. A supply cart was observed outside of the clean utility room had a minimal supply of one size incontinence briefs and minimal linen available. During an interview on 5/22/24 at 4:04 P.M., CNA #14 said they do not always have incontinence briefs, soap, gloves and laundry items to care for the residents on the unit and at times there don't have the supplies in the building because they are waiting for a shipment. She said that many of the CNAs bring in their own supplies to use for resident care because they want to make sure they are clean and cared for. CNA #14 said that they currently only have large incontinence briefs for residents and there are residents who need the extra large size but they have to use what they have. During an interview on 5/22/24 at 4:20 P.M., CNA #3 said the CNAs are struggling to have the needed supplies like soap and incontinence briefs. She said they currently only have one size incontinence briefs on the unit she works. She further said there are times when they have to purchase soap to use for the residents because they don't have soap. CNA #3 said at times, there is not enough wash clothes/towels. She said they used to have disposable wipes but they don't have those anymore. During an interview on 5/23/24 at 6:45 A.M., CNA #10 said that they don't always have supplies like towels, washcloths, soap, tissues, incontinence briefs. She said currently they only have small incontinence briefs which they are using on residents who need larger sizes and this has been a struggle for awhile. CNA #10 said that administration has been told and tell them that they are working on it and that supplies are coming. She said that some of the CNAs have to hide supplies so they have a stash to use for their residents and that she has had to purchase tissues, soap, and incontinence briefs for residents. During an interview on 5/23/24 at 6:54 A.M., CNA #15 said there are not enough incontinence briefs for the larger residents. She said that have regular and medium sized incontinence briefs but don't have the larger ones. She said when this occurs, the CNAs will double up and use two smaller incontinence briefs to make a larger one. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/23/24 at 6:59 A.M., CNA#9 said they recently went a long time without soap and incontinence briefs. She said if they don't have to needed size for incontinence briefs, they put a small size on and don't tape it closed. When administration is told, they respond and say the supplies are coming and then it doesn't come. During an interview on 5/23/24 at 7:09 A.M., CNA #16 said sometimes there is no soap or incontinence briefs available. She said that she purchases soap to use for residents care. During an interview on 5/23/24 at 9:52 A.M., the Director of Laundry/Maintenance said supplies are delivered to the units at 6:00 A.M., 2:00 P.M. and 9:00 P.M. He said he orders supplies monthly and if supplies are needed like linen, washcloths and towels, he can order them or can get them from sister facilities if needed immediately. During an interview on 5/23/24 at 12:49 P.M., a family member of a resident who resided at the facility said there were no towels in the facility on 5/22/24 because staff told her. She said she previously had to buy toilet paper for her family member and roommate because the facility ran out and they have had to purchase incontinence briefs and hide them because they run out. During an interview on 5/23/24 at 8:26 A.M., the Administrator said the central supply position has been vacant for about a week and currently the Assistant Director of Nurses (ADON) and the Unit Manager (UM) on Unit Two have been ordering the facility supplies. She said she was not aware of any issues with lack of supplies, that two large orders with supplies recently came in, but has only worked in the facility for 16 days. She further said the ADON, the UM and the Infection Preventionist (IP) check in with the staff about supplies and what is needed. During an interview on 5/23/24 at 10:52 A.M., the ADON said she took over ordering facility supplies since the beginning of April. She said that there is an order that is completed weekly for facility supplies and she speaks with staff about what items are needed and what is out so that it can be added to the list to order. The ADON said there was a recent delay in an delivery, she had to contact the person who handles their account in order to get the order delivered. She said that if supplies are low or unavailable, they could contact their sister facility to get those supplies or they could purchase items from the store. The ADON said she was made aware of the shortage of incontinence briefs on Tuesday (5/21/24) evening and an order was placed on Wednesday. She said she was not made aware that there were continued to be a shortage of incontinence briefs on Wednesday and did not check in with staff about the supplies. The surveyor relayed concerns expressed by residents present in resident council as well as facility staff on the units about supplies and the ADON said she was not aware of any other resident supplies that were lacking. She said that if the incorrect incontinence briefs have been used for residents there could be a concern of skin breakdown. She further said that the facility is currently working on levels of what to order for supplies and that it felt like structure was needed.

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44129 Based on observation, interview, and record review, the facility failed to establish and implement policies, in accordance with applicable Federal, State and local laws and regulations regarding smoking for two Residents (#82 and #244) out of four applicable residents out of a total sample of 21 residents. Specifically, the facility failed to: 1. Ensure their smoking policy addressed what preventative measures were in place in the event of a fire emergency. 2. The facility failed to ensure they implemented their smoking policy relative to two Residents (#82 and #244) relative to possession of smoking materials. Finding include: Review of the Department of Health and Human Services Centers for Medicare and Medicaid Services Memorandum titled, Smoking Safety in Long Term Care Facilities, dated 11/10/11 included but was not limited to: - Facilities must include assessment of smoking areas and provision of emergency equipment in the designated smoking areas. - The facility is obligated to ensure the safety of designated smoking areas .the facility is also required to provide portable fire extinguishers in all facilities 1. The facility failed to ensure their smoking policy addressed what preventative measures were in place in the event of a fire emergency. Review of the facility policy titled Smoking, revised 3/2022, indicated the following: -Smoking is only permitted in designated resident smoking areas, which are located outside of the building. -Metal containers, with self-closing cover devices, are available in smoking areas - Residents who have independent smoking privileges are not permitted to keep cigarettes, pipes, tobacco, and other smoking articles in their possession. - Residents without independent smoking privileges may not have or keep any smoking articles including cigarettes, tobacco, etc., except when they are under direct supervision. Further review of the facility smoking policy did not indicate what fire prevention equipment should be available in the smoking areas or what preventative measures were to be implemented in the event of a fire emergency related to smoking. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. The facility failed to ensure they implemented their smoking policy relative to two Residents (#82 and #244) relative to possession of smoking materials. During an observation of resident smoking and a concurrent interview on 5/21/24 from 9:27 A.M. until 9:35 A.M., the surveyor observed three Residents (#82, #244, and #245) outside smoking accompanied by Certified Nursing Assistant (CNA) #5. The surveyor asked CNA #5 if the residents were allowed to keep their cigarettes on their person or if they were required to have their smoking paraphernalia locked up on the unit. CNA #5 said Resident #82 and Resident #245 had permission to keep cigarettes in their possession, but Resident #244 was not allowed to keep cigarettes in his/her possession. At that time, Resident #244 spoke up and said he/she kept his/her cigarettes in his/her possession because, they trust me with them. 2a. Resident #82 was admitted to the facility in October 2023 with a diagnosis of Dementia. Review of the Resident's most recent Minimum Data Set (MDS) assessment dated [DATE] indicated the Resident had moderate cognitive impairment as evidenced by a Brief Interview for Mental Status (BIMS) score of 11 out of a possible 15. Further review of the MDS assessment indicated the Resident was able to make him/herself understood and understood others. Review of the Resident's Smoking Safety Screen dated 10/13/23 indicated the Resident was a smoker, required supervision, and that the Resident required the facility to store lighter and cigarettes. Review of the Resident's Smoking Care Plan dated 10/24/23 and revised on 5/6/24 indicated the Resident required supervised smoking, smoking materials were to be stored in a secured area and the smoking policy was to be reviewed with the Resident and/or his/her health care representative. During an observation and interview on 5/21/24 at 9:11 A.M., the surveyor observed Resident #82 seated in his/her wheelchair on the nursing unit waiting for a staff member to take him/her outside to smoke. Resident #82 said he/she goes outside approximately three times per day, depending on when staff were available to take him/her outside. Resident #82 then said that he/she keeps his/her cigarettes with him/her pointing to a small, zippered bag next to him/her on the wheelchair, and that staff trust him/her to keep the cigarettes with him/her. During an observation and interview on 5/23/24 at 9:05 A.M., Resident #82 said he/she was waiting to go outside to smoke and opened his/her zippered bag next to him/her on his/her wheelchair and showed the surveyor a pack of cigarettes in his/her bag. During an observation of resident smoking on 5/23/24 from 10:05 A.M. until 10:35 A.M., the surveyor observed Resident #82, with the assistance of the Activity Director, remove a cigarette from a pack of cigarettes Resident #82 removed from his/her zippered bag, and the Activity Director assisted the Resident in lighting his/her cigarette. 2b. Resident #244 was admitted to the facility in May 2024 with diagnoses including: Fractured Femur, Chronic Obstructive Pulmonary Disease (COPD, a group of diseases that block airflow and make it difficult to breathe), and Dementia. Review of the Nursing Admission assessment dated [DATE] indicated the Resident was oriented to person, place, and time. (continued on next page)

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F 0926 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Resident's Smoking Evaluation dated 5/13/24 indicated the Resident was a smoker, required supervision and smoking materials were to be stored by the facility. Review of the Resident's Smoking Care Plan dated 5/10/24 and revised on 5/17/24 indicated the Resident required supervised smoking and was to wear a smoking apron while smoking. During an observation of resident smoking on 5/21/24 from 9:27 A.M. until 9:35 A.M., the surveyor observed the Resident smoking without a smoking apron. During an observation on 5/23/24 at 9:50 A.M., the Resident showed surveyor a pack of cigarettes he/she keeps in his/her nightstand and said he/she was allowed to keep them because they trusted him/her. During an interview on 5/22/24 at 4:00 P.M., CNA #6 said he often brings residents outside to smoke and residents were not allowed to keep smoking materials in their possession due to safety concerns. During an interview concurrent with resident smoking observation on 5/23/24 from 10:05 A.M. until 10:35 A.M., CNA #4 said there have not been many residents who were smokers in the building until very recently. CNA #4 said there was no system in place to ensure the residents' smoking materials were secured and up until now there were no smoking aprons, no fire blankets, and no fire extinguisher available to staff who take the residents out to smoke. CNA #4 further said there should be a process in place to ensure resident safety and there was none. CNA #4 said that no resident was allowed to keep smoking materials on their person or in their rooms, and they were supposed to be secured by the nursing staff.